ScriptGuideRX Direct Member Reimbursement Form

Directions: (Please read carefully and fill out the entire form.)

- 1) This form **must** be completely filled out in order to process your claim(s).
- 2) Attach all prescription receipt(s) to the back of this form.
- 3) Prescription receipts must contain all of the following information or they will not be accepted: RX number, Date filled, Physician, Drug Name with NDC number, Strength, Quantity, Days Supply and Prescription Charge.

**** Store cash register receipts will not be accepted, the receipt(s) **MUST** contain the above information.

4) Sign the form and mail with receipts to:

ScriptGuideRX 15400 East Jefferson Avenue **Grosse Pointe Park, MI 48230**

If you have any questions/concerns please call member services at: 855-855-SGRX (7479) ♦ Monday – Friday: 8:30AM to 5:00PM FST

Please allow 4 weeks from the time you mail your request.								
Member Information: (This is the individual for whom the prescription was written). Please Print								
Member Name								
Mailing Address				Member's Contact Phone Number				
City	/ StateZip Code			Member ID Number (as it appears on Rx card)				
Sex: Male/Female Date of Birth								
Prescription Information:								
RxNumber	Date Rx Filled	Physician's Name and / or NPI Number	Drug Nam	e and NDC #	Strength	Quantity	Days Supply	Amount Paid
***** Are these reimbursement(s) for Secondary Coverage? Please Circle I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim(s) upon request from the claims administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form. MEMBER SIGNATURE: DATE:								